Ptarmigan Pediatrics
3543 E Meridian Park Lp, Ste A
Wasilla, AK 99654
Phone: (907) 357-4KID (4543)
Fax: (907) 357-4533
ptarmiganpediatrics.com

Patient Registration Form

Mother ☐Bio-mother ☐Stepmother ☐Guardian ☐Other:_____

Full Name_____ **SSN** _____ **DOB** _____
Mailing Address _____ **Zip code** _____
Physical Address _____ **Zip code** _____
Home/Work (circle one) Phone _____ **Cell Phone** _____
Email: _____**Preferred Contact Method: ☐ Home Phone☐ Cell Phone☐ Work Phone**

Father ☐Bio-father ☐Stepfather ☐Guardian ☐Other:_____

Full Name_____ **SSN** _____ **DOB** _____
Mailing Address (if different than above) _____ Zip code _____
Physical Address _____ Zip code _____
Home/Work (circle one) Phone _____ **Cell Phone** _____
Email: _____**Preferred Contact Method: ☐ Home Phone☐ Cell Phone☐ Work Phone**

Preferred Pharmacy _____

Family's Preferred Language (although we cannot guarantee we can communicate with you!)**:** ☐ English | ☐ Other: _____

***** INSURANCE INFO** (present card(s) to front desk) **☐ Self Pay** ****THIS SECTION MUST BE FILLED OUT****

Primary Insurance Company:_____ Policy#:_____ Group#:_____
Policy Holder's Name: _____SSN: _____ DOB: _____
Secondary Insurance Company: _____Policy#:_____ Group#:_____
Policy Holder's Name: _____SSN: _____ DOB: _____

1. **Child's Full Name** _____ **Date of Birth** _____ **Gender:** □ M □ F
   Race: □ African American, □ AK. Native/American Indian, □ Asian, □ Pacific Islander, □ White, □ Other_____
   Ethnicity: □ Hispanic or Latino, □ Not Hispanic or Latino

2. **Child's Full Name** _____ **Date of Birth** _____ **Gender:** □ M □ F
   Race: □ African American, □ AK. Native/American Indian, □ Asian, □ Pacific Islander, □ White, □ Other_____
   Ethnicity: □ Hispanic or Latino, □ Not Hispanic or Latino

3. **Child's Full Name** _____ **Date of Birth** _____ **Gender:** □ M □ F
   Race: □ African American, □ AK. Native/American Indian, □ Asian, □ Pacific Islander, □ White, □ Other_____
   Ethnicity: □ Hispanic or Latino, □ Not Hispanic or Latino

4. **Child's Full Name** _____ **Date of Birth** _____ **Gender:** □ M □ F
   Race: □ African American, □ AK. Native/American Indian, □ Asian, □ Pacific Islander, □ White, □ Other_____
Ethnicity: □ Hispanic or Latino, □ Not Hispanic or Latino

****** If you have more than 4 children, please see the front desk for an additional page ******

★ ***Signature of parent or legal guardian*:** _____ ***Date:*** _____

Printed name of Parent or Legal Guardian: _____

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HIPAA Acknowledgement, Office Policies, Assignment of Benefits

*If you are submitting this remotely, please mail/fax this completed form with a copy of Insurance & ID card(s) to the address at the top of this page.

By signing below, I, _____, hereby…
(Printed name of parent or legal guardian)

1. …acknowledge **receipt of or access to Ptarmigan Pediatrics, HIPAA / Privacy Notice** and recognize that changes to this policy may occur at any time without notice. I will always have access to the most recent Notice at the clinic website: *www.ptarmiganpediatrics.com* or posted in the clinic office waiting room. **I may request a written copy at any time**.

2. …believe that Ptarmigan Pediatrics is **committed to providing the highest quality medical care** for my family members aged birth through 17 years, and consent to have these facilities provide care for my child(ren).

3. …commit to **canceling appointments** with as much notice as possible, and understand that failure to notify this office of my inability to keep any appointment will result in a "no-show." Repeated no-shows are serious and may involve a fine which must be paid prior to the child being seen again in this clinic, acceptance at the clinic on a walk-in basis only (as time allows), or both. Insurances do NOT cover no-show charges. Patients **over 15 minutes tardy** may be asked to reschedule.

4. …understand that Ptarmigan Pediatrics is proud to be a **mentoring / training facility** for students in health related fields, who may provide care to my child under the supervision of the licensed clinical staff.

5. …agree that **my child cannot be seen in this clinic without a parent or legal guardian** (or my representative designated in writing) being present. "Guardianship agreement" forms are available in our office or via download on our website.

6. … understand that I am responsible **for providing complete, accurate, and up-to-date insurance and billing information**. I assume responsibility for any balance not covered by my child's insurance, including those resulting from incomplete, inaccurate or outdated information that I provide.

7. …authorize Ptarmigan Pediatrics, to **submit claims to my child's insurance company(s)** on my child's behalf, and my child's insurance company(s) to pay benefits directly to Ptarmigan Pediatrics.

8. …understand that should any insurance payment be made directly to me for monies due on this account, I agree to immediately pay over these funds to Ptarmigan Pediatrics.

9. …understand that **an "out-of-network" insurance carrier may limit payments** for any or all services provided by Ptarmigan Pediatrics / Ptarmigan Connections, regardless of the advertised benefits package. (i.e., they may pay less than our standard charges, even if they advertise "100% benefit").

10. …agree that upon acceptance of services provided by Ptarmigan Pediatrics, **I assume responsibility for any deductible, co-pay and coinsurance, *as well as any other balance not covered by my child's insurance carrier*. Copays and estimated coinsurances are due at the time of service.** If my account is turned over to **Cornerstone Credit Services** for collections**, I agree to pay any resulting collection and legal fees**.

11. Furthermore, I understand that if I personally pay all billed charges in full at the time of service, I am eligible for **"prompt-pay/self-pay discount."**

Name(s) of Children / Patients: _____

Printed Name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____**Date:**_____

A photocopy of this assignment is considered to be as valid as the original.